

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

Texas Democratic Party, Gilbert Hinojosa, §
Chair of the Texas Democratic Party, §
Joseph Daniel Cascino, Shanda Marie §
Sansing, and Brenda Li Garcia, §
Plaintiffs, §
§
v. § Civil Action No. 5:20-CV-00438-FB
§
Greg Abbott, Governor of Texas; Ruth §
Hughs, Texas Secretary of State, Dana §
Debeauvoir, Travis County Clerk, and §
Jacquelyn F. Callanen, Bexar County §
Elections Administrator, §
Defendants. §

DECLARATION OF JEFFREY D. KLAUSNER, M.D., MPH

1. My name is Dr. Jeffrey D. Klausner. I am a Professor of Medicine in the Division of Infectious Diseases in the University of California Los Angeles, David Geffen School of Medicine and Adjunct Professor of Epidemiology in the Fielding School of Public Health.
2. In 1991, I earned my Medical Degree from Cornell University Medical College with Honors in Research. In 1994, I completed my Internship and Residency in Internal Medicine at the New York University—Bellevue Hospital Center. In June 1995, I earned my Master's in Public Health with a focus on International Health and Epidemiology at the Harvard School of Public Health.
3. From July 1995-June 1997, I was an Epidemic Intelligence Service Officer at the Centers for Disease Prevention and Control. I was the lead investigator on several disease outbreaks include a large respiratory disease outbreak in California.
4. In June 1998, I completed my Fellowship in Infectious Diseases at the University of Washington, Seattle.
5. From 1998-2009, I was a Deputy Health Officer, City and County of San Francisco, Director of STD Prevention and Control Services at the San Francisco Department of Public Health. During that time, I was voluntary faculty in infectious diseases and medicine at the UCSF School of Medicine, in the Divisions of AIDS and Infectious Diseases and Attending Physician at San Francisco General Hospital. While in San Francisco, I helped identify key factors associated with the increased spread of HIV and other sexually transmitted diseases and implemented multiple novel public health prevention programs.
6. From 2009-2011, I was Branch Chief for HIV and TB at the Centers for Disease Control in Pretoria, South Africa, helping South Africa in their AIDS and tuberculosis prevention, control and treatment activities. I was the lead U.S. surveillance officer for Gauteng Province

for the World Cup, 2010. In 2012, I joined the faculties of the UCLA School of Medicine and Public Health.

7. I have over 520 peer-reviewed publications in infectious disease prevention, control and treatment in journals such as Science and the New England Journal of Medicine. My research interests are in applied epidemiology and the prevention and control of communicable diseases. I am currently a Principal Investigator funded by the U.S. National Institutes of Health, Centers for Disease Control and Prevention, and several pharmaceutical and diagnostic test manufacturers to study new ways to identify, control and treat infectious diseases. I am a frequent advisor to the CDC, NIH and WHO and am a member of the CDC STD Treatment Guidelines work group, review groups for the National Institute of Allergy and Infectious Diseases of the NIH and WHO groups on antimicrobial resistance and STD treatment. I also have advised the National Academy of Medicine Public Health group.
8. I am the recipient of the 2016 Centers for Disease Control Jack N. Spencer Award given to honor individuals for a career of exceptional contributions to excellence in STD prevention characterized by outstanding commitment to science-based programs, continuous innovation, and profound commitment to helping people
9. During the Covid-19 epidemic, I am serving as the medical director for a large Covid-19 testing laboratory, and have advised Los Angeles City and County officials on Covid-19 prevention and control as well as San Francisco officials, other county health officers, members of the California State Assembly and California Governor's Office.
10. I currently practice medicine and consult in clinical infectious diseases at UCLA Health's Ronald Reagan Medical Center and Santa Monica Hospital taking care of complex patients with Covid-19, immunodeficiency and difficult to diagnose and treat infections.
11. I was course co-chair for the UCLA School of Medicine infectious disease and immunology curriculum and am a regular lecturer in public health and infectious disease epidemiology in the undergraduate curriculum and in the graduate School of Public Health.
12. I regularly serve as a thesis advisor to graduate students in infectious disease epidemiology.
13. From 2014-2018, I served as an election poll worker in Los Angeles County.

Description of COVID-19 and Methods of Transmission

14. Covid-19 is a disease caused by the novel Severe Acute Respiratory Virus Coronavirus-2 (SARS-CoV-2). SARS-CoV-2 is endemic in bats in China. I believe SARS-CoV-2 entered the human population sometime between October and December 2019 in Wuhan, China. Based on virological studies the intermediary host may be pangolins.
15. SARS-CoV-2 infects human cells that line and form the salivary glands, upper and lower respiratory tract.
16. SARS-CoV-2 is spread via respiratory droplets, small droplets of saliva and mucous that are expelled from an infected human during coughing, sneezing, singing or speaking. Those respiratory droplets fall to the ground or surfaces typically within a radius of 6 feet.
17. Persons may be exposed to SARS-CoV-2 through direct contact with contaminated surfaces and self-inoculation of infectious virus onto mucous membranes of the eyes, nose or mouth.
18. The duration of infectious SARS-CoV-2 respiratory droplets on surfaces is typically less than 24 hours by may vary by surface type. That duration is impacted by ultraviolet light, temperature and humidity.

19. Persons may also be exposed by directly inhaling respiratory droplets spread by infectious individuals in close proximity (i.e., within 6 feet).
20. SARS-CoV-2 respiratory droplets do not become droplet nuclei—small dried droplets of virus that may linger in the air for prolonged periods similar to *Mycobacterium tuberculosis* and spread through closed heating, ventilation, or air-conditioning systems.
21. Well-documented large outbreaks of SARS-CoV-2 have occurred on cruise ships, in nursing homes, medical facilities, in meatpacking plants, households, restaurants and within churches. All of those venues are associated with prolonged exposure, crowding, and contaminated surfaces.
22. Outdoor events have rarely been associated with outbreaks likely due to the air or wind acting to disperse droplets, the sanitizing effects of sunlight (i.e., ultra-violet radiation) and absence of crowding.
23. SARS-CoV-2 is not spread by water contamination or exposure, food, oral-fecal contact, or vectors such as mosquitoes, ticks or fleas.

Severity of COVID-19 in Different Patient Populations

24. I have been taking care of patients with SARS-CoV-2 infection since the beginning of the epidemic in Los Angeles, both outpatients and inpatients in the hospital. I have consulted with other physicians on the clinical management of Covid-19 cases.
25. Infection with SARS-CoV-2 may be severe and lead to death in some individuals. The estimated mortality rate among all those infected is about 0.5%. The mortality rate greatly increases with age with those more than age 80 years, experiencing a greater than 10% mortality.
26. Elderly persons and those with chronic disease are particularly vulnerable to severe disease requiring hospitalization, and intensive unit care including mechanical ventilation.
27. Chronic diseases such as heart disease, obesity, diabetes, hypertension, and lung disease increase the risk of severe disease and death. There are higher rates of undiagnosed and untreated chronic diseases among some populations in the United States.
28. Younger persons under age 65 years of age and those otherwise healthy are at low risk of hospitalization and death. Those under age 44 years of age are at very low risk of hospitalization and death:

COVID-19 Epidemiologic Data, New York City, May 9, 2020¹

AGE GROUP	Cases	Hospitalizations	Deaths
0-17 years	254.61	18.07	0
18-44 years	1934.75	185.71	17.12
45-64 years	3165.39	737.63	157.68
65-74 years	3163.99	1439.96	515.36

¹ See <https://www1.nyc.gov/site/doh/covid/covid-19-data.page> (accessed 5.9.20).

75 and older years	3718.09	2275.97	1289.09
Citywide total	2113.18	526.94	172.43

Impact of COVID-19 on Texas

- 29. Every epidemic is local. For example, New York State has had significantly higher reported cases of Covid-19 than Texas.
- 30. Differences in personal behavior, climate, crowding, household density and public transportation use contribute to important differences in the frequency and distribution of cases.
- 31. According to data obtained from the Texas Department of State Health Services, as of May 11, 2020, among 254 counties in Texas, 35 counties have no reported cases, 57 counties have fewer than 5 reported cases and on 44 have more than 100 cases.²
- 32. As of May 11, 2020, Texas (with a population of approximately 28 million) has conducted about 501,776 Covid-19 tests.³
- 33. The current rate of new cases per day in Texas is stable or declining. The number of new cases peaked on April 9, 2020.⁴
- 34. The test positivity rate in Texas has declined from a peak of approximately 15.9% on April 11, 2020, to approximately 5.9% on May 9, 2020.⁵ Per Federal guidelines, test positivity of less than 10% meet targets for adequate testing.
- 35. While approximately 1,700 Covid-19 cases are currently hospitalized, there are adequate hospital and intensive care unit beds.
- 36. Based on the absence of epidemic spread in urban areas, the relatively modest number and rate of new cases in Texas in March and April 2020 since first the reported case of SARS-Covid-2 on March 5, 2020 and the current availability of testing, awareness and education measures in place that have impacted personal behavior change, it is highly unlikely that cases, hospitalizations, and deaths will increase over the summer months and in the fall of 2020.
- 37. Due to climate conditions in the summer and increased outdoor personal activity, historically summer months have low disease activity for respiratory infections.
- 38. International settings with early Covid-19 outbreaks such as China, South Korea, Singapore and Japan have not observed second waves or peaks of infections.
- 39. Personal behavior changes such as staying home when ill, avoiding ill contacts, handwashing, household and workplace cleaning, decreased handshaking and hugging, covering sneezes and coughs can have profound effects on the spread of respiratory infections.

² See <https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/ed483ecd702b4298ab01e8b9cafc8b83> (accessed 5.11.20).

³ See <https://covidtracking.com/data> (accessed 5.11.20).

⁴ See <https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/ed483ecd702b4298ab01e8b9cafc8b83> (accessed 5.11.20).

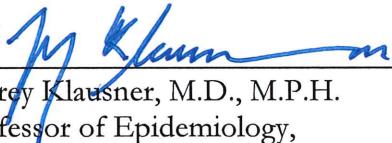
⁵ See <https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/ed483ecd702b4298ab01e8b9cafc8b83> (accessed 5.11.20).

Safety of Elections in Texas

40. As a volunteer election poll worker in Los Angeles County, I am very familiar with the election poll site, interpersonal interactions, crowding and opportunities to practice social distancing and maintain clean high-touch surfaces.
41. There are practical measures that Texas counties can implement to protect the health of voters and poll workers.
42. For example, I have reviewed the May 8 2020, declaration of Bruce Sherbet, Elections Administrator for Collin County. He provides a list of reasonable and effective measures to reduce the likelihood of exposure to Covid-19 for voters and poll workers. Those evidence-based measures focus on social distancing, decontamination, reduction of possible transmission and monitoring to assess the impact of those measures on future gatherings for elections.
43. The absence of a substantial outbreak event or increases in cases associated with the April 7, 2020, Wisconsin election (approximately 440,000 in person voters) suggests that voting may be done safely without increased risk.⁶
44. It is my expert opinion that, with the reasonable measures in place similar to those described in the Texas Secretary of State Election Advisory No. 2020-14 on April 6, 2020⁷ and those contained within declaration of Bruce Sherbet, Texas may hold safe elections in the summer and fall of 2020. Under those circumstances, the risk of attending election polling sites would be no greater than visiting a grocery store.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 11, 2020.



Jeffrey Klausner, M.D., M.P.H.
Professor of Epidemiology,
UCLA Fielding School of Public Health
&
Professor of Medicine, Division of Infectious
Diseases
UCLA David Geffen School of Medicine

⁶ See <https://www.cbsnews.com/news/no-spike-but-no-certainty-on-fallout-of-wisconsin-election/> (accessed 5.9.20).

⁷ See <https://www.sos.state.tx.us/elections/laws/advisory2020-14.shtml> (accessed 5.11.20).